FOR OFFICE USE ONLY

Application for Basic Health™

NOTE: ***Use blue or black ink to complete this application.***
Your social security number is voluntary except where noted.

Questions? Call 1-800-826-2444

Si desea ayuda en español, llame al 1-800-321-0291. Для обслуживания на русском языке, позвоните, пожалуйста, по телефону 1-800-387-8224.
한국어로 도움을 원하시면 1-800-324-1658로 연락하십시오. Nếu quý vị muốn được giúp bằng tiếng Việt, xin gọi số 1-800-423-2231.

Section 1 APPLICANT AND HOUSEHOLD INFORMATION

If you need help in a language other than English, what language ***and dialect*** *do you speak?* _____

Proof of your street address listed below is required (not a P.O. box).

Applicant's last name	First name			M.I.
Street address (attach proof) Apt. #	City	County	State	ZIP Code
Mailing address or P.O. box (if different from above)	City		State	ZIP Code

Home phone number ( ) Daytime phone number ( )

Marital status (check one): ❑ Single ❑ Separated ❑ Legally married - Date of marriage: _____

Section 2 COVERAGE FOR APPLICANT AND SPOUSE

Complete this section for applicant and legal spouse ***even if not*** *requesting coverage.*

	Social security number	Birth date	Sex	Requesting coverage?	U.S. citizen?	Receiving DSHS medical assistance?
For applicant listed above →			❑ M ❑ F	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Spouse's last name, first name, M.I.	Social security number	Birth date	❑ M ❑ F	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Do you have family members currently receiving social security disability benefits? ❑ Yes ❑ No

If "yes," *list them here, and attach copies of the original and current award letters for each:*

Do you have family members eligible for Medicare (the federal health program for people over age 65 or people who have been on social security disability for more than two years)? ❑ Yes ❑ No

If "yes," *list them here:* _____

Section 3 HEALTH PLAN SELECTION AND ADDITIONAL PROGRAM CHOICES

CHOOSE ONE HEALTH PLAN FOR YOUR FAMILY

Not all health plans are available in every county. Read *How Much Will Basic Health Coverage Cost?* to see the plans available where you live.

CHECK ONE...

- ❑ Aetna USHC of WA
- ❑ Columbia United Providers, Inc. (CUP)
- ❑ Community Health Plan of Washington
- ❑ Group Health Cooperative
- ❑ Kaiser
- ❑ Molina
- ❑ Premera Blue Cross
- ❑ Regence BlueShield

ARE YOU APPLYING FOR:

- Basic Health *Plus* for a child under 19 on this application? ❑ Yes ❑ No
- Basic Health *Plus* for a child with an urgent medical need? ❑ Yes ❑ No
- Coverage for someone who is currently pregnant? ❑ Yes ❑ No
  If yes, *attach proof that shows pregnant woman's name and due date. Proof must be from your doctor, clinic, or mid-wife.*
  Due date: _____ Provider's name: _____ Phone # _____
- Basic Health *Plus* or the Maternity Benefits Program, and want to be referred to DSHS for help with unpaid medical bills from the last three months? ❑ Yes ❑ No
  If yes, *attach proof of income for those three months.*

Social security numbers are required if you answered "yes" to any of these questions.

TYPE OF COVERAGE (CHECK ONE):

- ❑ Individual/family coverage **OR**
- ❑ Group coverage (through an employer, home care agency, or financial sponsor)

Complete this part only if your premium will be paid in full or in part by your employer, home care agency, or financial sponsor. *(Return the completed application directly to your group contact.)*

Employer/organization _____ Group I.D. number _____ Daytime phone number ( ) _____

◀ Please detach at perforation ◀

Section 4 LEGAL DEPENDENTS *(If more than three, list on a separate sheet or copy this page.)*

List all of your legal dependents, *even if not requesting coverage and/or not living in your home. Do not list foster children. Dependents aged 19, 20, 21, or 22 must be attending an accredited school full-time to be listed on your application.*

1	Last name, first name, M.I.	Relationship to applicant ❑ Son or daughter ❑ Other: _____	Social security number	Birth date	Sex ❑ M ❑ F	
Enroll in Basic Health? ❑ Yes ❑ No	Enroll in Basic Health *Plus*? ❑ Yes ❑ No	Is dependent a full-time student? ❑ Yes ❑ No School: _____	Is dependent a U.S. citizen? ❑ Yes ❑ No	Is dependent receiving DSHS medical assistance? ❑ Yes ❑ No	Is dependent living in the home full-time? ❑ Yes ❑ No	
2	Last name, first name, M.I.	Relationship to applicant ❑ Son or daughter ❑ Other: _____	Social security number	Birth date	Sex ❑ M ❑ F	
Enroll in Basic Health? ❑ Yes ❑ No	Enroll in Basic Health *Plus*? ❑ Yes ❑ No	Is dependent a full-time student? ❑ Yes ❑ No School: _____	Is dependent a U.S. citizen? ❑ Yes ❑ No	Is dependent receiving DSHS medical assistance? ❑ Yes ❑ No	Is dependent living in the home full-time? ❑ Yes ❑ No	
3	Last name, first name, M.I.	Relationship to applicant ❑ Son or daughter ❑ Other: _____	Social security number	Birth date	Sex ❑ M ❑ F	
Enroll in Basic Health? ❑ Yes ❑ No	Enroll in Basic Health *Plus*? ❑ Yes ❑ No	Is dependent a full-time student? ❑ Yes ❑ No School: _____	Is dependent a U.S. citizen? ❑ Yes ❑ No	Is dependent receiving DSHS medical assistance? ❑ Yes ❑ No	Is dependent living in the home full-time? ❑ Yes ❑ No	

Are you applying for any dependents who don't live in your home full-time? ***If so,*** *complete the following.*

Name	Address	City	County	State	ZIP Code

If you checked "yes" in any of the "Enroll in Basic Health *Plus*?" boxes above, do you **want to pay** for regular Basic Health until DSHS starts paying your children's premium for Basic Health *Plus*? ❑ Yes ❑ No
If yes, refer to *How Much Will Basic Health Coverage Cost?*, and include the additional amount due for any dependents with your application.

Do you pay court-ordered child support? If so, how much per month do you pay? $ _____ ❑ Yes ❑ No
(This may help you qualify for Basic Health *Plus* or the Maternity Benefits Program.)

Have you checked "no" to "U.S. Citizen?" for any family member applying for Basic Health *Plus* or the Maternity Benefits Program? ***If so,*** *please provide a copy (front and back) of the INS documentation, and indicate the date of arrival into the United States.* ❑ Yes ❑ No

Are any of your dependents (age 19 or over) disabled or otherwise under your legal guardianship? ❑ Yes ❑ No
If so, *attach a copy of legal guardianship papers.*

Are any disabled dependents receiving social security disability? ***If so,*** *attach a copy of the eligibility award letter for* ***each*** *disabled* dependent. ❑ Yes ❑ No

Section 5 OTHER BIOLOGICAL PARENT (IF LIVING IN THE HOME)

Are you applying for Basic Health *Plus* coverage for a child whose other biological parent is not legally married to you, but is living in your home? (This information is used to determine Basic Health *Plus* eligibility only. If this person wants coverage, he or she must submit a separate application.) ❑ Yes ❑ No
If you checked "yes" above, *you must fill in this information about that parent.*
Attach proof of this person's income.

Name of other biological parent	Social security number (required)	Birth date	Gross income	Daytime phone number
				( )

List the names of this parent's children shown on your application:

_____

_____

_____

▶ Please detach at perforation ▶

Section 6 VOLUNTARY INFORMATION

Completing this section is voluntary and will not affect your ability to enroll, but may help us to better assist you.

ETHNIC BACKGROUND

- ❑ Black/African-American
- ❑ White/Caucasian
- ❑ Indian (Native American)
- ❑ Eskimo
- ❑ Aleutian Islander/Aleut
- ❑ Asian or Pacific Islander (API)
  Specify: _____
- ❑ Hispanic/Latin American
  Specify: _____
- ❑ Other or mixed ethnic background
  Specify: _____

WHERE DID YOU GET YOUR APPLICATION?

- ❑ Family/friend
- ❑ Local, nonprofit organization
- ❑ Web site
- ❑ Medical office/hospital/clinic
- ❑ Government office, such as DSHS or your local health department
- ❑ Other: _____

Section 7 FAMILY INCOME

Applicant's name: _____

HOW DO YOU WANT YOUR INCOME CALCULATED? (CHECK ONE)

❑ Check here if you want your premium based on your most current consecutive 30 days of income/benefits or wages.

OR

❑ Check here if you want your premium based on an average of your income. You must submit proof of at least three, but not more than six, current/consecutive months' income. If you choose to "income average," your premium will be locked in for six months.

If you are applying for Basic Health *Plus* or the Maternity Benefits Program, DSHS will not average your income to determine your eligibility.

Attach a copy of proof for **each source of income and/or benefits for all months.**

In all cases, include your IRS Form 1040 (not W-2) or call the IRS (1-800-829-1040 or 1-800-829-8815) and request an IRS transcript. If you did not file taxes, ask for an IRS verification of non-filing status.

Do not send original documents. They will not be returned.

LIST NAME(S) OF ALL CURRENT EMPLOYERS FOR:

Self: _____

Spouse: _____

STATEMENT OF ZERO INCOME

❑ Check this box and sign below if **you** have had **no income or benefits** in the last 30 days.

❑ Check this box and have your spouse sign below if **your spouse** has had **no income or benefits** in the last 30 days.

_____ _____ _____ _____

Self Date Spouse Date

If you have not received a full 30 current/consecutive days of income or benefits for any source of income you list on the "Family Income Worksheet" (Section 7 of the application), please explain why here.
Also explain any periods for which you don't have documentation.

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____ _____

Self Date Spouse Date

◀ Please detach at perforation ◀

Section 7 FAMILY INCOME (Continued)

Family Income Worksheet

Income/benefit source	Monthly amount (before taxes)	SEND A COPY OF:
1. Gross wages, salary, commissions, tips (including overtime and bonuses)	SELF $ _____ SPOUSE AND/OR CHILD $ _____	Pay stubs for the most recent consecutive 30 days (must show pay dates/periods, your name, and gross income).
2. *Self-employment or rental income (profit or loss) from Form A or B	SELF $ _____ SPOUSE $ _____	(UBI #:_____) Completed "Self-Employment and Rental Income Worksheet" (must include IRS Form 1040 and all schedules).
3. Unemployment compensation	SELF $ _____ SPOUSE $ _____	Most recent 30 days of unemployment stubs (four current/consecutive weeks)
4. Social security retirement, survivor, disability, or supplemental security income benefits (circle type received)	SELF $ _____ SPOUSE AND/OR CHILD $ _____ BENEFITS FOR ALL CHILDREN $ _____	Most recent benefits and/or award letter received for the current year.
5. Retirement or pensions	SELF $ _____ SPOUSE $ _____	Pay stub, award letter, benefit statement showing your current monthly benefit, or pension award letter showing monthly benefit.
6. Child support, family support or alimony received	SELF $ _____ SPOUSE AND/OR CHILD $ _____	Statement signed by person paying child support or alimony, copy of checks, court documents, or Office of Support Enforcement statement, for the most recent 30 days. NAME CHILD RECEIVING: _____
7. Insurance benefits (monthly awards)	SELF $ _____ SPOUSE AND/OR CHILD $ _____	Award letter or benefit statement from the insurance company showing your current month's benefit. NAME CHILD RECEIVING: _____
8. Interest, dividends, trust, annuity	SELF $ _____ SPOUSE AND/OR CHILD $ _____	Current statement (monthly, quarterly, or semi-annual) for all sources. If not supplied, will be averaged from IRS Form 1040. NAME CHILD RECEIVING: _____
9. Veterans benefits/military allotments	SELF $ _____ SPOUSE AND/OR CHILD $ _____	Award letter or benefit statement showing your current monthly benefit. NAME CHILD RECEIVING: _____
10. L & I (workers' compensation)	SELF $ _____ SPOUSE $ _____	L & I statement(s) showing current/consecutive 30 days (two current/consecutive 14-day statements).
11. Public assistance (DSHS cash grants; do not include food stamps)	SELF $ _____ SPOUSE $ _____	Award letter showing your current monthly benefit and dates received.
12. Other: (Please explain.)	SELF $ _____ SPOUSE AND/OR CHILD $ _____	NAME CHILD RECEIVING: _____
	SUBTOTAL $ _____	
	Subtract work-related child care expenses - $ _____	Copies of receipts. If married, both parents must be employed to deduct child care expenses.
	TOTAL MONTHLY GROSS INCOME $ _____	**This amount will be used to determine your monthly Basic Health premium.**

**If you are self-employed, complete the "Self-Employment and Rental Income Worksheet" (Form A or Form B and/or Form C) on the following pages. Transfer the total profit or loss from your "Self-Employment and Rental Income Worksheet" (Form A or B) to this "Family Income Worksheet," in box 2 above.*

▶ Please detach at perforation ▶

Self-Employment or Rental Income Worksheet (FORM A)

Applicant's name: _____

Use this form (Form A) only if you are self-employed and filed income taxes (IRS Form 1040) for the last calendar year. If you have not yet filed taxes for this business, go to Form B.

- If you have more than one business, or you and your spouse are both self-employed, you will need to copy this form and complete one for each business.
- Complete this form and attach it to your application, along with your IRS Form 1040 and all schedules.
- Also complete Form C if you are applying for Basic Health Plus or the Maternity Benefits Program.
- If you are a sole proprietor or have rental property, complete Part 1 below.
- If your business is a partnership, complete Part 2 below.
- If your business is an "S-corporation," complete Part 3 below.

PART 1. SOLE PROPRIETOR or RENTAL INCOME

Name of business:				
Uniform Business Identifier (UBI) number:		Date business began:		
Using your IRS Form 1040 with your Schedule C, E, and/or F, complete the following. You must submit copies of IRS Form 1040 and Schedule C, E, and/or F.				
Line 1.	Gross income for year (from Schedule)			1. $
	a. Total expense for year (from Schedule)	1a. $		
	b. Expense for business use of home (from Schedule)	1b. $		
	c. One-half of self-employment tax from line 27 of IRS Form 1040	1c. $		
Line 2.	Add lines 1a, 1b, and 1c (above) and		ENTER HERE	2. $
Line 3.	Subtract line 2 from line 1 and		ENTER HERE	3. $
Line 4.	Divide the dollar amount in Line 3 (annual profit/loss) by 12 and		ENTER HERE	4. $ *

Line 4 is your total self-employment monthly income (or loss). Transfer this amount to the "Family Income Worksheet," box 2.

You must submit copies of all pages of your IRS Form 1040, and all schedules you filed.

◀ Please detach at perforation ◀

PART 2. PARTNERSHIP

Name of business:		
Uniform Business Identifier (UBI) number:	Date business began:	Your percentage of partnership:

- Review your IRS Form 1065 (U.S. Return of Partnership Income) and your IRS Form 1040 (U.S. Individual Income Tax Return).
- Add your "guaranteed payments to partners" from your IRS Form 1065 (Schedule K-1), and your profit or loss from Schedule E of your IRS Form 1040.
- Divide the result by 12 (or the number of months you were in business for the reporting calendar year).
- Enter the resulting monthly amount in box 2 of the "Family Income Worksheet."

You must submit copies of all pages/schedules of IRS Form 1040.
You must also include copies of your partnership return (IRS Form 1065, all pages/schedules, including K-1s).

PART 3. S-CORPORATION

Name of business:		
Uniform Business Identifier (UBI) number:	Date business began:	Type of corporation:

- Review your IRS Form 1120S (U.S. Income Tax Return for an S-Corporation) and your IRS Form 1040 (US Individual Income Tax Return) for the reporting calendar year.
- Divide your "compensation of officers" from IRS Form 1120S by 12 (or the number of months you were in business for the reporting calendar year). Enter the resulting monthly amount on line 1 of the "Family Income Worksheet." **Do not count your current monthly wages from the S-Corporation.** If there has been a change in your current "compensation to officers" amount, please include verification for the last 30 days.

You must submit copies all pages/schedules from your IRS Form 1040, IRS Form 1120S and Schedule K-1s.

Section 7 FAMILY INCOME (Continued)

Self-Employment or Rental Income Worksheet (FORM B)

Applicant's name: _____

Use this form only if you are self-employed and did not file taxes for your business in the last tax year.

- You must also complete Form C if you want Basic Health *Plus* or Maternity Benefits Program coverage.
- If you have more than one business, or you and your spouse are both self-employed, you will need to copy this form and complete one for each business.
- Complete this form and attach it to your application, along with all documentation.

Name of business:	
Uniform Business Identifier (UBI) number:	Date business began:

❑ SOLE PROPRIETORSHIP ❑ PARTNERSHIP (% OF PARTNERSHIP: _____) ❑ S-CORPORATION

Reporting period: List calendar months you are reporting since business began: ____ _____ thru ____ _____(such as July 2001 thru Sept. 2001)

Total number of months for the reporting period shown above:_____

(This section is used to figure a monthly average for the reporting period.)

	EXPENSES	INCOME
Line 1. Gross income, sales, or rental income		1. $
Line 2. Cost of goods	2. $	
Line 3. IRS-allowed expenses*	3. $	
Line 4. One-half self-employment taxes	4. $	
Line 5. Deduction of business use of home	5. $	
Line 6. Total allowable expenses (add lines 2, 3, 4, and 5)		**Total expense** 6. $
Line 7. Total self-employment profit/loss for months listed above (subtract line 6 from line 1).		**Total profit/loss** 7. $
Line 8. Divide total in line 7 by total number of months listed above. Enter that amount here and in box 2 of the "Family Income Worksheet."		**Average monthly profit/loss** 8. $

*IRS-allowed expenses include wages paid for salaries, advertising, car and truck expenses, insurance (non-medical), legal and professional services, rent/lease of business property/equipment, repairs/maintenance, supplies, or other IRS-allowed expenses. **You may be asked to provide proof of expenses. However, if you are applying for Basic Health *Plus* or the Maternity Benefits Program, you must provide information on all your gross receipts and expenses for the last complete calendar month.**

▶ Please detach at perforation ▶

DSHS Programs Self-Employment or Rental Income Worksheet (FORM C)

Use this form only if you're applying for Basic Health Plus and/or the Maternity Benefits Program. Complete this form in addition to Form A or Form B.

- For this form, use the dollar amounts from your most current complete full calendar month. **Do not total and do not transfer this page to the "Family Income Worksheet."** This form is to help DSHS determine your eligibility for Basic Health *Plus* and/or the Maternity Benefits Program.
- You must provide information on all your gross receipts and expenses for the last complete calendar month.
- If you are requesting DSHS help with unpaid medical bills from the last three months, you must copy and complete this form for each of those months.

Applicant's name: _____

Month of: _____

1. Name of business:	Type of business:
2. Business street address:	

❑ Partnership ❑ Incorporated ❑ Sole proprietorship

For partnerships and corporations, list members' names and relationships: _____

_____

If incorporated, monthly amount paid to you by corporation: $ _____

Check and complete if no longer self-employed.

❑ I am no longer self-employed

Date of last pay: _____

Last day worked: _____

Amount of last pay: $ _____

◀ Please detach at perforation ◀

Gross business income (month of report only)	$
Employees (not including yourself, your spouse, or your children): _____ _____	
Wages and commissions paid in month of report	$
Employer share of social security taxes paid in month of report	$
Business expenses (month of report only)	
Printing	$
Postage/shipping	$
Supplies/materials	$
Advertising/accounting	$
Insurance (business-related only)	$
Business licenses, trade dues, etc.	$
Business loan (interest paid only)	$
Business tax (sales, UI, L&I, B&O, etc.)	$
Other (list and describe):	
	$
	$
	$
	$

DSHS WILL TOTAL ALLOWABLE EXPENSES.

Business location	
Is business in your home?	❑ Yes ❑ No
If yes, is the room/area used for business purposes **only?**	❑ Yes ❑ No
If yes: Total square footage in your home:	
Square footage used for business:	
Rent (for business address or home business only)	$
Interest on your mortgage	$
Utilities (including telephone, electricity, water, etc.)	$
Business transportation costs	
Is your vehicle used for business only?	❑ Yes ❑ No
Total miles driven for month of report:	
Total miles driven **on the job** for month of report:	
Vehicle repairs for vehicle used for business (paid in month of report only)	$
Registration and license fees for vehicle used for business (paid in month of report only)	$
Interest only from payments on vehicles used for business (paid in month of report only)	$
Check and complete **one:** ❑ I want to deduct $.345 per mile for gas, oil, and fluids ❑ I want to deduct actual expenses for gas, oil, and fluids	$

Section 8 OTHER INSURANCE INFORMATION

INFORMATION ON OTHER HEALTH CARE COVERAGE

List yourself and any family members who have other health insurance or are covered under a health program (such as Tri-Care, Medicare, or Medicaid), even if they're not applying for Basic Health coverage.

*Complete the last three columns of the chart below (marked with an *) **only** if you are applying for Basic Health **Plus** or Maternity Benefits program coverage.*

Last Name **First Name** **M.I.**	Health insurance company or health program	Phone number of health insurance company or health program*	Policy or group number*	Policy end date*
(List yourself first.) 1.		( )		
2.		( )		

Section 9 AGREEMENT AND SIGNATURE

I understand that:

- I must provide proof of my gross family income (before taxes) and report income changes that would change my premium or eligibility to Basic Health/Department of Social and Health Services (DSHS) within 30 days after the end of the month that the new income was earned. My signature on this form authorizes Basic Health to verify my family income with other state or federal income reporting agencies.
- I must report address changes and changes in my family, for example, a marriage or divorce, the birth of a child, or a child who leaves the home or is no longer a dependent or full-time student.
- The information attached to this application may be verified by Basic Health and/or DSHS through contact with other state or federal agencies.
- This application and attachments may be used to determine eligibility for Medicaid (Basic Health *Plus* coverage or the Maternity Benefits Program).
- By asking for and receiving Medical Assistance benefits, my family and I assign to the state of Washington our rights to any third party payment for medical care of covered medical services while receiving medical benefits.
- Basic Health's deposit of my premium payment does not guarantee coverage. The payment will be refunded if I am determined ineligible for coverage.

I authorize any health plan or medical provider to give Basic Health medical records for myself or my children under age 18, for purposes of participation in Basic Health/Medical Assistance programs.

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application and attachments is true, correct, and complete to the best of my knowledge. I understand that anyone who submits false information may lose coverage, may be held financially responsible for services obtained under Basic Health or additional premium amounts due, and may face other penalties for prosecution and collection.

AGREEMENT MUST BE SIGNED BY ALL APPLICANTS OVER AGE 18

X Signature of applicant	Date	X Signature of spouse	Date

Signature of all others age 18 or over applying for coverage

X Signature	Date	X Signature	Date

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's (the agency that administers Basic Health) Privacy Notice is available upon request by calling 360-923-2822 or online at www.wa.gov/hca.

Section 10 IS YOUR APPLICATION COMPLETE?

Use this checklist below to make sure you include:

- ❑ Full 30 days of income information from all income sources.
- ❑ Current IRS Form 1040 with all schedules (W-2s not accepted).
- ❑ Documents showing your name and street address.
- ❑ Court order showing required child support you are paying (need for Basic Health *Plus* or the Maternity Benefits Program).
- ❑ Application signed by all family members over age 18 asking for coverage.
- ❑ Indicate your health plan choice on the first page of this application.
- ❑ Include the Permission Form (found in the "Dear Applicant" letter), if you'd like someone else to be able to access your account information.

Please enclose all required documentation and return in the envelope provided.

Mail to: Basic Health, P.O. Box 94213, Seattle WA 98124-6513

Questions? Call 1-800-826-2444
On the Internet, go to: www.wa.gov/hca/basichealth.htm

Basic Health™

Washington State Department of Social & Health Services

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